KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

RISK MANAGEMENT REPORT FORM

HELP

(Please attach additional sheets as needed)

Reporting Party: Name_____
Last First M. I. Position

Facility Name: _____Phone No.:_____

Address: _____E-mail address:_____
(Street/PO Box) (City) (9 digit Zip Code)

Reportable Incident Information

Incident # _____ Date of Incident: _____MM/DD/YY

Provider ID: _____
(Name & Certification number if applicable) certification #

Facts of the Incident (Description, date etc.):

Standard of Care (SOC) Determination: _____

Conclusion/Rationale for the SOC determination:

Actions taken:

Recommendations for Minimizing Future Occurrences:

Return this report to:
Risk Management Program
Bureau of Child Care and Health Facilities
Kansas Department of Health and Environment
1000 SW Jackson Street, Suite 200
Topeka, Kansas 66612-1365

RF/RM 09/2003

PRINT RESET